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MAKING SENSE OF, AND RESPONDING SENSIBLY TO, PSYCHOSIS

What is ‘Psychosis’?

When we encounter extreme states of confusion, distress or despair, in others or ourselves, we need to call it something. Our brains seem to be programmed to need a word, or label, to describe our experience, to ourselves, and to others. Perhaps this need for a category is particularly strong when we are observing something particularly unusual or distressing. ‘Psychosis’ is one such word. It is one of many. ‘Crazy’, ‘mad’ and ‘insane’ describe much the same phenomena. When I ask my undergraduate classes to think of as many such words as they can within 60 seconds the winner usually manages over 20, often including ‘bananas’, bonkers’, and some variation on ‘not playing with a full deck’. Perhaps what they all have in common is the idea of losing contact with reality, of experiencing things that most people do not experience, such as hearing voices or believing that all red cars are driven by someone out to get you.

One of the attractions of words like ‘psychosis’ is that they can convey the illusion that they explain something. We might think ‘Aha, now I understand why that person is saying those things and acting that way… it is because they have psychosis’. We assume that this thing called ‘psychosis’ that they have inside them is what is causing them to hear the scary voices and have the bizarre beliefs. The word ‘psychosis’, however, is just a word. It explains nothing

Furthermore, experts cannot even agree on who has this thing and who does not. Jim Geekie, a Scottish clinical psychologist, argues that ‘madness’ is, like ‘truth’, ‘justice’ and ‘beauty’, an ‘essentially constructed concept’, meaning that it inevitably involves endless disputes about what it is (Geekie & Read, 2009). The diagnosis most representative of psychosis is ‘schizophrenia’. More than 100 years since its first usage our diagnostic experts have certainly failed, spectacularly, to come up with a definition that all can agree with. The latest edition of the Diagnostic and Statistical Manual of Mental Disorders still lists five types of symptoms for schizophrenia (American Psychiatric Association, 2013). You only need two of the five to get the diagnosis. So, if you have just ‘delusions’ and ‘disorganised speech’, and I have just ‘delusions’ and ‘disorganised behavior’, we have nothing in common, but are given the same diagnosis… ‘schizophrenia’. In scientific circles this is called a ‘dysjunctive’ construct and is immediately discarded. There are a range of ruder words for this in ordinary language, with ‘nonsense’ at the more polite end of the spectrum.

Unsurprisingly, ‘schizophrenia’ has no reliability, meaning that there is little or no agreement on who has it. It also has no validity, the term scientists use to describe whether a construct is related to, or can predict, other variables, such as outcome and response to treatments (Bentall, 2003; Read, 2013).

Yet many mental health professionals, especially psychiatrists, genuinely believe that some people have this thing called ‘schizophrenia’, that it is an illness with a genetic predisposition, and that the unusual thoughts, feelings and behaviours of some people are somehow caused by this thing. These professionals even feel comfortable sharing their unsubstantiated opinions with the person having the unusual experiences and their loved ones.

Although words like ‘psychosis’ or ‘schizophrenia’ are just words, and explain nothing, they are, nevertheless, very powerful. They convey a pessimistic (and inaccurate) message that there is something irreversibly wrong with your genes or brain and that there is very little, therefore, that one can do to help oneself, or others. Although these labels can being some temporary relief, via the illusions of having discovered what is wrong and that the doctors know how to treat it, the long term disadvantages, including the stigma and prejudice that accompany the label (Read, Haslam, & Magliano, 2013), have been described by many as more troublesome than the original problems that led to the diagnosis in the first place (Shulze & Angermeyer, 2003).

So, when trying to figure out how to help others, or yourself, when extremely disoriented or distressed, try not to spend too much time thinking about what to call it. Consider asking two other questions instead: ‘What happened to you?’ and ‘What do you need?’

What are the Causes?

When surveys ask the public what causes ‘schizophrenia’ or psychosis they emphasise psycho-social factors such as poverty, stress, unemployment, loss, abuse, and neglect, over bio-medical factors such as genetics and the brain. This has been found in the following 22 diverse countries: Australia, Bali, Brazil, China, England, Egypt, Ethiopia, Fiji, France, Germany, Greece, Ireland, India, Italy, Japan, Malaysia, Mongolia, New Zealand, Russia, South Africa, Switzerland and Turkey (Read, Magliano, & Beavan, 2013).

People who have been labelled ‘schizophrenic’ are, it seems, even more likely than the rest of the population to believe in psycho-social causes. A review found that all 16 samples, from nine countries, prioritised thing like losses, family conflicts, and traumas over genetics, biochemistry etc. (Read, Magliano, & Beavan, 2013). Interestingly, however, this insistence that one does not have an illness, or that one’s problems are socially not medically based, is typically dismissed as a ‘lack of insight’ which is then characterised as a symptom of the very illness, ‘schizophrenia’ that you don’t think you have. Indeed an international study of 306 ‘typical schizophrenics’ found that this ‘lack of insight’ was the most common symptom (97%), exceeding both hallucinations (74%) and delusions (64%) (Murray & Dean, 2008). Psychiatrists actually believe they have found the part of the brain that causes these disagreements with psychiatrists (Raij, Riekki, & Hari, 2012).

It seems, however, that the public, including those deemed ‘schizophrenic’, are right. There is far more research evidence for psycho-social causes than for bio-genetic causes. Space does not permit critiques of the simplistic genetic and brain-based theories of ‘psychosis’ or ‘schizophrenia’, although there have been many (e.g. Bentall, 2003; Joseph, 2013). Most researchers have abandoned both the overactive dopamine theory that dominated for decades and the search for the schizophrenia gene.

There is overwhelming evidence that hearing voices, being extremely paranoid and so on are socially caused (Read, 2013b). There is, of course, no single cause. For most people the probability of ending up with a diagnosis of ‘schizophrenia’ is increased by a *combination* of the following factors (Bentall, 2013; Read & Dillon, 2013):

- Poverty
- Relative poverty (difference between wealthiest and poorest)
- Maternal prenatal health and stress
- Birth complications
- Child abuse
- Child neglect
- Early loss of parent(s)
- Bullying
- Heavy early cannabis use
- Lack of friends in adolescence

- Rape
- Physical assault
- Urban living
- Racism (especially in combination with isolation from one's ethnic group)
- War trauma
- Exile as a refugee

For example, a meta-analysis of the 41 most rigorous studies conducted by 2012 found that people who had suffered one or more childhood adversities were nearly three times more likely to develop psychosis than non-abused people (Varese et al., 2012). Nine of the ten studies that tested for a dose-response found it; meaning that the greater the severity of the abuse etc., the greater the probability of psychosis. Adults scoring highly on the *Adverse Childhood Experiences* scale are 10 times more likely to be prescribed antipsychotics (Anda et al., 2007).

Obviously, not everyone who has been abused or raped, or has grown up in extreme poverty, is destined to hear distressing voices or be very paranoid. And not all psychosis is caused by trauma and adversity – just most of it. So it is very important for anyone wanting to help (professional, family or friend) to ask 'What happened to you?' Research suggests this is still not happening for the majority of people who come into contact with mental health services.

Helpful Responses

It is not helpful, or evidence-based, to ignore what has gone on, and is going on now, in people's lives and tell them instead that they have something wrong with their brains and/or genes. It is not helpful, or evidence-based, to tell them their difficulties are caused by some illusory concept called 'schizophrenia' or 'psychosis'. It is not helpful, or evidence-based, to assume that everyone benefits from ‘anti-psychotic’ medication, which is actually no better than placebo for most recipients and has such severe adverse effects that the majority discard them within a few months (Hutton et al., 2013).

Services

There are a number of developments that try to avoid these mistakes. Sadly, these types of services, despite often being shown to be more effective than ‘treatment as usual’, tend to be less available. Summarising these in a couple of sentences each is hard to do well.

The Soteria House model, based on the work of psychiatrist Loren Mosher in the USA, and emphasising residential support in an ordinary house with non-professional staff, is, despite its excellent evidence-base (Mosher & Hendricks, 2005), available in only three of four cities in the world.

The Open Dialogue approach, from Finland, has gained impressive traction in the USA, Europe and Australasia (http://open-dialogue.net). This model places great emphasis on involving a network of family and friends as early as possible. Much less emphasis is placed on medication than by traditional, mainstream services.

The UK, USA and Australasia have seen, for two decades now, the growth of Early Intervention for Psychosis, or First Episode, services (Johannessen et al., 2013). And there have been efforts to prevent psychosis in ‘at risk’ youth, although identifying who is at risk has been largely elusive. Although most of these services employ psychologists, counsellors and psychotherapists, in most the majority of service users are still medicated.

Probably the most evidence-based approach of all of the new approaches is Cognitive Behavioural Therapy for psychosis (CBTp). Unlike medication, CBTp is not designed to eradicate symptoms. It is designed to reduce the stress associated with those thoughts or behaviours – a completely different approach (Morrison, 2002). This would seem to be in line with the ‘Recovery movement’, if a core component of that movement is aiming for the highest possible quality of life (self-defined) regardless of the presence or absence of ‘symptoms’.

Another progressive trend is the emergence of Trauma-Informed services. This involves engaging with people in ways that facilitate recovery from the adversities that led to the mental health problems, and avoid re-traumatising through practices such as the use of force (Sweeney, Clements, Filson, & Kennedy, 2016).

Perhaps the most exciting recent development is the growth of the *Hearing Voices Netwo*rk. Organisations exist in 26 countries, training staff how to respond sensitively and/or facilitating peer-support groups where voice-hearers can discuss the origins of their voices and share what works for them, without being pathologised or medicated (www.intervoiceonline.org). Early research findings are promising (Beavan, de Jager, & dos Santos, 2017; Ruddle, 2017).

Another important occurrence is the growth of the International Society for Psychological and Social Approaches to Psychosis (www.isps.org), initiated by Italian psychoanalysts in the 1950s to keep alive psychological understandings of psychosis after the introduction of chlorpromazine. ISPS today has branches in over 20 countries, embracing all psychological approaches as well as service users and family members.

Principles

I think there are some values that all these approaches share, and which differentiate them from mainstream biological psychiatry. These shared principles might be useful prompts for all of us, professional, friend or family member. They include:

- Focus on being with rather than doing to
- Ask what the problem is – and listen

- Ask what has happened to them – and listen
- Encourage a search for meaning, including possible links between negative life experiences and current problems
- Ask what they need – and, if reasonable, try to find a way for that to be provided
- If there are safety concerns talk about what would work
- Listen some more
- Ask whom else the person would like to be involved in helping them through the crisis
- Instil hope that things will get better
- Make a plan together

All this, of course, is the sort of thing you would do if a family member or friend told you they needed help with other sorts of problems. That is the whole point. One thing that seems to link all the more effective and humane approaches together is a broad understanding that the feelings, thoughts and behaviours we put, for convenience sake, in the ‘psychosis’ box are (rather like dreams) meaningful responses to external and internal events in our lives, not some meaningless spasm of the dopamine system or a genetically predetermined malfunction. This understanding leads to a more human and humane response, based on respect and concern. If the causes of human misery are primarily the result of the negative, negating actions of other human beings then the most effective remedy will probably be positive, affirming actions of other human beings towards us.

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